[COMMITTEE PRINT]

June 16, 1999

[As Approved by the Subcommittee on Employer-Employee Relations on June 16, 1999]

106TH CONGRESS 1ST SESSION H. R. 2089

To amend title I of the Employee Retirement Income Security Act of 1974 to provide new procedures and access to review for grievances arising under group health plans.

IN THE HOUSE OF REPRESENTATIVES

June 9, 1999

Mr. Boehner introduced the following bill; which was referred to the Committee on Education and the Workforce

[Strike out all after the enacting clause and insert the part printed in italic] [For text of introduced bill, see copy of bill as introduced on June 8, 1999]

A BILL

To amend title I of the Employee Retirement Income Security Act of 1974 to provide new procedures and access to review for grievances arising under group health plans.

- 1 Be it enacted by the Senate and House of Representa-
- 2 tives of the United States of America in Congress assembled,

SECTION	1	SHORT	TITLE

2	This Act may be cited as the "Group Health Plan Re-
3	view Standards Act of 1999".
4	SEC. 2. SPECIAL RULES FOR GROUP HEALTH PLANS.
5	(a) In General.—Section 503 of the Employee Re-
6	tirement Income Security Act of 1974 (29 U.S.C. 1133) is
7	amended—
8	(1) by inserting "(a) In General.—" after
9	"Sec. 503.";
10	(2) by inserting "(other than a group health
11	plan)" after "employee benefit plan"; and
12	(3) by adding at the end the following new sub-
13	section:
14	"(b) Special Rules for Group Health Plans.—
15	"(1) Coverage determinations.—Every group
16	health plan shall—
17	"(A) provide adequate notice in writing in
18	accordance with this subsection to any partici-
19	pant or beneficiary of any adverse coverage deci-
20	sion with respect to benefits of such participant
21	or beneficiary under the plan, setting forth the
22	specific reasons for such coverage decision and
23	any rights of review provided under the plan,
24	written in a manner calculated to be understood
25	by the average participant;

1	"(B) provide such notice in writing also to
2	any treating medical care provider of such par-
3	ticipant or beneficiary, if such provider has
4	claimed reimbursement for any item or service
5	involved in such coverage decision, or if a claim
6	submitted by the provider initiated the proceed-
7	ings leading to such decision;
8	"(C) afford a reasonable opportunity to any
9	participant or beneficiary who is in receipt of
10	the notice of such adverse coverage decision, and
11	who files a written request for review of the ini-
12	tial coverage decision within 90 days after re-
13	ceipt of the notice of the initial decision, for a
14	full and fair review of the decision by an appro-
15	priate named fiduciary who did not make the
16	initial decision; and
17	"(D) meet the additional requirements of
18	this subsection.
19	"(2) Time limits for making initial cov-
20	ERAGE DECISIONS FOR BENEFITS AND COMPLETING
21	INTERNAL APPEALS.—
22	"(A) Time limits for deciding requests
23	FOR BENEFIT PAYMENTS, REQUESTS FOR AD-
24	VANCE DETERMINATION OF COVERAGE, AND RE-
25	QUESTS FOR REQUIRED DETERMINATION OF

1	MEDICAL NECESSITY.—Except as provided in
2	subparagraph (B)—
3	"(i) Initial decisions.—If a request
4	for benefit payments, a request for advance
5	determination of coverage, or a request for
6	required determination of medical necessity
7	is submitted to a group health plan in such
8	reasonable form as may be required under
9	the plan, the plan shall issue in writing an
10	initial coverage decision on the request be-
11	fore the end of the initial decision period
12	under paragraph $(10)(I)$ following the filing
13	completion date. Failure to issue a coverage
14	decision on such a request before the end of
15	the period required under this clause shall
16	be treated as an adverse coverage decision
17	for purposes of internal review under clause
18	(ii).
19	"(ii) Internal reviews of initial
20	Denials.—Upon the written request of a
21	participant or beneficiary for review of an
22	initial adverse coverage decision under
23	clause (i), a review by an appropriate
24	named fiduciary (subject to paragraph (3))
25	of the initial coverage decision shall be com-

1	pleted, including issuance by the plan of a
2	written decision affirming, reversing, or
3	modifying the initial coverage decision, set-
4	ting forth the grounds for such decision, be-
5	fore the end of the internal review period
6	following the review filing date. Such deci-
7	sion shall be treated as the final decision of
8	the plan, subject to any applicable reconsid-
9	eration under paragraph (4). Failure to
10	issue before the end of such period such a
11	written decision requested under this clause
12	shall be treated as a final decision affirm-
13	ing the initial coverage decision.
14	"(B) Time limits for making coverage
15	DECISIONS RELATING TO ACCELERATED NEED
16	MEDICAL CARE AND FOR COMPLETING INTERNAL
17	APPEALS.—
18	"(i) Initial decisions.—A group
19	health plan shall issue in writing an initial
20	coverage decision on any request for expe-
21	dited advance determination of coverage or
22	for expedited required determination of
23	medical necessity submitted, in such reason-
24	able form as may be required under the
25	plan before the end of the accelerated need

1	decision period under paragraph $(10)(K)$,
2	in cases involving accelerated need medical
3	care, following the filing completion date.
4	Failure to approve or deny such a request
5	before the end of the applicable decision pe-
6	riod shall be treated as a denial of the re-
7	quest for purposes of internal review under
8	clause (ii).
9	"(ii) Internal reviews of initial
10	DENIALS.—Upon the written request of a
11	participant or beneficiary for review of an
12	initial adverse coverage decision under
13	clause (i), a review by an appropriate
14	named fiduciary (subject to paragraph (3))
15	of the initial coverage decision shall be com-
16	pleted, including issuance by the plan of a
17	written decision affirming, reversing, or
18	modifying the initial converge decision, set-
19	ting forth the grounds for the decision before
20	the end of the accelerated need decision pe-
21	riod under paragraph (10)(K) following the
22	review filing date. Such decision shall be
23	treated as the final decision of the plan,
24	subject to any applicable reconsideration
25	under paragraph (4). Failure to issue before

1	the end of the applicable decision period
2	such a written decision requested under this
3	clause shall be treated as a final decision af-
4	firming the initial coverage decision.
5	"(3) Physicians must review initial cov-
6	ERAGE DECISIONS INVOLVING MEDICAL APPROPRIATE-
7	NESS OR NECESSITY OR INVESTIGATIONAL ITEMS OR
8	EXPERIMENTAL TREATMENT.—If an initial coverage
9	decision under paragraph $(2)(A)(i)$ or $(2)(B)(i)$ is
10	based on a determination that provision of a particu-
11	lar item or service is excluded from coverage under
12	the terms of the plan because the provision of such
13	item or service does not meet the plan's requirements
14	for medical appropriateness or necessity or would
15	constitute provision of investigational items or experi-
16	mental treatment or technology, the review under
17	paragraph $(2)(A)(ii)$ or $(2)(B)(ii)$, to the extent that
18	it relates to medical appropriateness or necessity or
19	to investigational items or experimental treatment or
20	technology, shall be conducted by a physician who is
21	selected by the plan and who did not make the initial
22	denial.
23	"(4) Elective external review by inde-
24	PENDENT MEDICAL EXPERT AND RECONSIDERATION
25	OF INITIAL REVIEW DECISION —

1	"(A) In general.—In any case in which a
2	participant or beneficiary, who has received an
3	adverse coverage decision which is not reversed
4	upon review conducted pursuant to paragraph
5	(1)(C) (including review under paragraph
6	(2)(A)(ii) or $(2)(B)(ii))$ and who has not com-
7	menced review of the coverage decision under sec-
8	tion 502, makes a request in writing, within 30
9	days after the date of such review decision, for
10	reconsideration of such review decision, the re-
11	quirements of subparagraphs (B), (C), (D) and
12	(E) shall apply in the case of such adverse cov-
13	erage decision, if the requirements of clause (i),
14	(ii), or (iii) are met.
15	"(i) Medical appropriateness or
16	INVESTIGATIONAL ITEM OR EXPERIMENTAL
17	TREATMENT OR TECHNOLOGY.—The require-
18	ments of this clause are met if such coverage
19	decision is based on a determination that
20	provision of a particular item or service
21	that would otherwise be covered under the
22	terms of the plan is excluded from coverage
23	under the terms of the plan because the pro-
24	vision of such item or service—

1	"(I) does not meet the plan's re-
2	quirements for medical appropriateness
3	or necessity; or
4	"(II) would constitute provision of
5	an investigational item or experi-
6	mental treatment or technology.
7	"(ii) Categorical exclusion of
8	ITEM OR SERVICE REQUIRING EVALUATION
9	OF MEDICAL FACTS OR EVIDENCE.—The re-
10	quirements of this clause are met if—
11	"(I) such coverage decision is
12	based on a determination that a par-
13	ticular item or service is not covered
14	under the terms of the plan because
15	provision of such item or service is cat-
16	egorically excluded from coverage
17	under the terms of the plan, and
18	"(II) an independent contract ex-
19	pert finds under subparagraph (C), in
20	advance of any review of the decision
21	under subparagraph (D), that such de-
22	termination primarily requires the
23	evaluation of medical facts or medical
24	evidence by a health professional.

1	"(iii) Specific exclusion of item
2	OR SERVICE REQUIRING EVALUATION OF
3	MEDICAL FACTS OR EVIDENCE.—The re-
4	quirements of this clause are met if—
5	"(I) such coverage decision is
6	based on a determination that a par-
7	ticular item or service is not covered
8	under the terms of the plan because
9	provision of such item or service is spe-
10	cifically excluded from coverage under
11	the terms of the plan, and
12	"(II) an independent contract ex-
13	pert finds under subparagraph (C), in
14	advance of any review of the decision
15	under subparagraph (D), that such de-
16	termination primarily requires the
17	evaluation of medical facts or medical
18	evidence by a health professional.
19	"(iv) Matters specifically not
20	SUBJECT TO REVIEW.—The requirements of
21	subparagraphs (B), (C), (D), and (E) shall
22	not apply in the case of any adverse cov-
23	erage decision if such decision is based on—
24	"(I) a determination of eligibility
25	for benefits,

1	"(II) the application of explicit
2	plan limits on the number, cost, or du-
3	ration of any benefit, or
4	"(III) a limitation on the amount
5	of any benefit payment or a require-
6	ment to make copayments under the
7	terms of the plan.
8	Review under this paragraph shall not be avail-
9	able for any coverage decision that has pre-
10	viously undergone review under this paragraph.
11	"(B) Limits on allowable advance pay-
12	MENTS.—The review under this paragraph in
13	connection with an adverse coverage decision
14	shall be available subject to any requirement of
15	the plan (unless waived by the plan for financial
16	or other reasons) for payment in advance to the
17	plan by the participant or beneficiary seeking
18	review of an amount not to exceed the greater of
19	(i) the lesser of \$100 or 10 percent of the cost of
20	the medical care involved in the decision, or (ii)
21	\$25, with such dollar amount subject to com-
22	pounded annual adjustments in the same man-
23	ner and to the same extent as apply under sec-
24	tion 215(i) of the Social Security Act, except
25	that, for any calendar year, such amount as so

1	adjusted shall be deemed, solely for such calendar
2	year, to be equal to such amount rounded to the
3	nearest \$10. No such payment may be required
4	in the case of any participant or beneficiary
5	whose enrollment under the plan is paid for, in
6	whole or in part, under a State plan under title
7	XIX or XXI of the Social Security Act. Any such
8	advance payment shall be subject to reimburse-
9	ment if the recommendation of the independent
10	medical expert or experts under subparagraph
11	(D)(iii) is to reverse or modify the coverage deci-
12	sion.
13	"(C) Request to independent contract
14	EXPERTS FOR DETERMINATION OF WHETHER
15	COVERAGE DECISION REQUIRED EVALUATION OF
16	MEDICAL FACTS OR EVIDENCE.—
17	"(i) In general.—In the case of a re-
18	quest for review made by a participant or
19	beneficiary as described in subparagraph
20	(A), if the requirements of clause (ii) or
21	(iii) of subparagraph (A) are met (and re-
22	view is not otherwise precluded under sub-
23	paragraph $(A)(iv))$, the terms of the $plan$
24	shall provide for a procedure for initial re-
25	view by an independent contract expert se-

1	lected by the plan under which the expert
2	will determine whether the coverage decision
3	requires the evaluation of medical facts or
4	evidence by a health professional. If the ex-
5	pert determines that the coverage decision
6	requires such evaluation, reconsideration of
7	such adverse decision shall proceed under
8	this paragraph. If the expert determines
9	that the coverage decision does not require
10	such evaluation, the adverse decision shall
11	remain the final decision of the plan.
12	"(ii) Independent contract ex-
13	PERTS.—For purposes of this subparagraph,
14	the term 'independent contract expert'
15	means a professional—
16	"(I) who has appropriate creden-
17	tials and has attained recognized ex-
18	pertise in the applicable area of con-
19	$tract\ interpretation;$
20	"(II) who was not involved in the
21	initial decision or any earlier review
22	thereof; and
23	"(III) who is selected in accord-
24	ance with subparagraph $(G)(i)$ and

1	meets the requirements of subpara-
2	$graph\ (G)(ii).$
3	"(D) Reconsideration of initial review
4	DECISION.—
5	"(i) In general.—In the case of a re-
6	quest for review made by a participant or
7	beneficiary as described in subparagraph
8	(A), if the requirements of subparagraph
9	(A)(i) are met or reconsideration proceeds
10	under this paragraph pursuant to subpara-
11	graph (C), the terms of the plan shall pro-
12	vide for a procedure for such reconsider-
13	ation in accordance with clause (ii).
14	"(ii) Procedure for reconsider-
15	ATION.—The procedure required under
16	clause (i) shall include the following—
17	"(I) One or more independent
18	medical experts will be selected in ac-
19	cordance with subparagraph (F) to re-
20	consider any coverage decision de-
21	scribed in subparagraph (A) to deter-
22	mine whether such decision was in ac-
23	cordance with the terms of the plan
24	and this title.

1	"(II) The record for review (in-
2	cluding a specification of the terms of
3	the plan and other criteria serving as
4	the basis for the initial review deci-
5	sion) will be presented to such expert
6	or experts and maintained in a man-
7	ner which will ensure confidentiality of
8	such record.
9	"(III) Such expert or experts will
10	reconsider the initial review decision to
11	determine whether such decision was in
12	accordance with the terms of the plan
13	and this title. Such reconsideration
14	shall include the initial decision of the
15	plan, the medical condition of the pa-
16	tient, and the recommendations of the
17	treating physician. The experts shall
18	take into account in the course of such
19	reconsideration any guidelines adopted
20	by the plan through a process involv-
21	ing medical practitioners and peer-re-
22	viewed medical literature identified as
23	such under criteria established by the
24	Food and Drug Administration.

1	"(IV) Such expert or experts will
2	issue a written decision affirming,
3	modifying, or reversing the initial re-
4	view decision, setting forth the grounds
5	for the decision.
6	"(E) Time limits for reconsider-
7	ATION.—Any review under this paragraph (in-
8	cluding any review under subparagraph (C))
9	shall be completed before the end of the reconsid-
10	eration period (as defined in paragraph $(10)(L)$)
11	following the review filing date in connection
12	with such review. The decision under this para-
13	graph affirming, reversing, or modifying the ini-
14	tial review decision of the plan shall be the final
15	decision of the plan. Failure to issue a written
16	decision before the end of the reconsideration pe-
17	riod in any reconsideration requested under this
18	paragraph shall be treated as a final decision af-
19	firming the initial review decision of the plan.
20	"(F) Independent medical experts.—
21	"(i) In general.—For purposes of
22	this paragraph, the term 'independent med-
23	ical expert' means, in connection with any
24	coverage decision by a group health plan, a
25	professional—

1	"(I) who is a physician or, if ap-
2	propriate, another medical profes-
3	sional;
4	"(II) who has appropriate creden-
5	tials and has attained recognized ex-
6	pertise in the applicable medical field;
7	"(III) who was not involved in
8	the initial decision or any earlier re-
9	view thereof;
10	"(IV) who has not history of dis-
11	ciplinary action or sanctions (includ-
12	ing, but not limited to, loss of staff
13	privileges or participation restriction)
14	taken or pending by any hospital,
15	health carrier, government, or regu-
16	latory body; and
17	"(V) who is selected in accordance
18	with subparagraph (G)(i) and meets
19	the requirements of subparagraph
20	(G)(ii).
21	"(G) Selection of experts.—
22	"(i) In General.—An independent
23	contract expert or independent medical ex-
24	pert is selected in accordance with this
25	clause if—

1	"(I) the expert is selected by an
2	intermediary which itself meets the re-
3	quirements of clause (ii), by means of
4	a method which ensures that the iden-
5	tity of the expert is not disclosed to the
6	plan, any health insurance issuer offer-
7	ing health insurance coverage to the
8	aggrieved participant or beneficiary in
9	connection with the plan, and the ag-
10	grieved participant or beneficiary
11	under the plan, and the identities of
12	the plan, the issuer, and the aggrieved
13	participant or beneficiary are not dis-
14	closed to the expert; or
15	"(II) the expert is selected, by an
16	intermediary or otherwise, in a man-
17	ner that is, under regulations issued
18	pursuant to negotiated rulemaking,
19	sufficient to ensure the expert's inde-
20	pendence, including selection by the
21	plan in cases where it is determined
22	that a suitable intermediary is not rea-
23	sonably available,
24	and the method of selection is devised to
25	reasonably ensure that the expert selected

1	meets the independence requirements of
2	clause (ii).
3	"(ii) Independence require-
4	MENTS.—An independent contract expert or
5	independent medical expert or another en-
6	tity described in clause (i) meets the inde-
7	pendence requirements of this clause if—
8	"(I) the expert or entity is not af-
9	filiated with any related party;
10	"(II) any compensation received
11	by such expert or entity in connection
12	with the external review is reasonable
13	and not contingent on any decision
14	rendered by the expert or entity;
15	"(III) under the terms of the plan
16	and any health insurance coverage of-
17	fered in connection with the plan, the
18	plan and the issuer (if any) have no
19	recourse against the expert or entity in
20	connection with the external review;
21	and
22	"(IV) the expert or entity does not
23	otherwise have a conflict of interest
24	with a related party as determined

1	under any regulations which the Sec-
2	retary may prescribe.
3	"(iii) Related party.—For purposes
4	of clause (i)(I), the term 'related party'
5	means—
6	"(I) the plan or any health insur-
7	ance issuer offering health insurance
8	coverage in connection with the plan
9	(or any officer, director, or manage-
10	ment employee of such plan or issuer);
11	"(II) the physician or other medi-
12	cal care provider that provided the
13	medical care involved in the coverage
14	decision;
15	"(III) the institution at which the
16	medical care involved in the coverage
17	decision is provided;
18	"(IV) the manufacturer of any
19	drug or other item that was included
20	in the medical care involved in the cov-
21	erage decision; or
22	"(V) any other party determined
23	under any regulations which the Sec-
24	retary may prescribe to have a sub-

1	stantial interest in the coverage deci-
2	sion.
3	"(iv) Affiliated.—For purposes of
4	clause $(ii)(I)$, the term 'affiliated' means, in
5	connection with any entity, having a famil-
6	ial, financial, or professional relationship
7	with, or interest in, such entity.
8	"(H) Misbehavior by experts.—Any ac-
9	tion by the expert or experts in applying for
10	their selection under this paragraph or in the
11	course of carrying out their duties under this
12	paragraph which constitutes—
13	"(i) fraud or intentional misrepresen-
14	tation by such expert or experts, or
15	"(ii) demonstrates failure to adhere to
16	the standards for selection set forth in sub-
17	paragraph (G)(ii),
18	shall be treated as a failure to meet the require-
19	ments of this paragraph and therefore as a cause
20	of action which may be brought by a fiduciary
21	under section $502(a)(3)$.
22	"(5) Permitted Alternatives to required
23	INTERNAL REVIEW.—
24	"(A) In General.—In accordance with
25	such regulations (if any) as may be prescribed

1	by the Secretary for purposes of this paragraph,
2	in the case of any initial coverage decision for
3	benefits under paragraph $(2)(A)(ii)$ or $(2)(B)(ii)$,
4	a group health plan may provide an alternative
5	dispute resolution procedure meeting the require-
6	ments of subparagraph (B) for use in lieu of the
7	procedures set forth under the preceding provi-
8	sions of this subsection relating review of such
9	decision. Such procedure may be provided in one
10	form for all participants and beneficiaries or in
11	a different form each group of similarly situated
12	participants and beneficiaries.
13	"(B) Requirements.—An alternative dis-
14	pute resolution procedure meets the requirements
15	of this subparagraph, in connection with any
16	initial coverage decision, if—
17	"(i) such procedure is utilized solely—
18	"(I) accordance with the applica-
19	ble terms of a bona fide collective bar-
20	gaining agreement pursuant to which
21	the plan (or the applicable portion
22	thereof governed by the agreement) is
23	established or maintained, or
24	"(II) upon election by all parties
25	to such decision,

1	"(ii) the procedure incorporates time
2	limits not exceeding the time limits other-
3	wise applicable under paragraphs (2)(A)(ii)
4	and $(2)(B)(ii)$;
5	"(iii) the procedure incorporates any
6	otherwise applicable requirement for review
7	by a physician under paragraph (3), unless
8	waived by the participant or beneficiary (in
9	a manner consistent with such regulations
10	as the Secretary may prescribe to ensure eq-
11	uitable procedures); and
12	"(iv) the means of resolution of dispute
13	allow for adequate presentation by each
14	party of scientific and medical evidence
15	supporting the position of such party.
16	"(C) Waivers.—In any case in which uti-
17	lization of the alternative dispute resolution pro-
18	cedure is voluntarily elected by all parties in
19	connection with a coverage decision, the plan
20	may require or allow under such procedure (in
21	a manner consistent with such regulations as the
22	Secretary may prescribe to ensure equitable pro-
23	cedures) any party to waive review of the cov-
24	erage decision under paragraph (3), to waive
25	further review of the coverage decision under

1	paragraph (4) or section 502, and to elect an al-
2	ternative means of external review (other than
3	review under paragraph (4)).
4	"(6) Permitted Alternatives to required
5	EXTERNAL REVIEW.—A group health plan shall not be
6	treated as failing to meet the requirements of this sub-
7	section in connection with review of coverage deci-
8	sions under paragraph (4) if the aggrieved partici-
9	pant or beneficiary elects to utilize a procedure in
10	connection with such review which is made generally
11	available under the plan (in a manner consistent
12	with such regulations as the Secretary may prescribe
13	to ensure equitable procedures) under which—
14	"(A) the plan agrees in advance of the rec-
15	ommendations of the independent medical expert
16	or experts under paragraph (4)(C)(iii) to render
17	a final decision in accordance with such rec-
18	ommendations; and
19	"(B) the participant or beneficiary waives
20	in advance any right to review of the final deci-
21	sion under section 502.
22	"(7) REVIEW REQUIREMENTS.—In any review of
23	a decision issued under this subsection—
24	"(A) the record below shall be maintained
25	for purposes of review in accordance with stand-

1	ards which shall be prescribed in regulations of
2	the Secretary designed to facilitate such review,
3	and
4	"(B) any decision upon review which modi-
5	fies or reverses a decision below shall specifically
6	set forth a determination that the record upon
7	review is sufficient to rebut a presumption in
8	favor of the decision below.
9	"(8) Compliance with fiduciary stand-
10	ARDS.—The issuance of a decision under a plan upon
11	review in good faith compliance with the require-
12	ments of this subsection shall not be treated as a vio-
13	lation of part 4.
14	"(9) Group Health Plan Defined.—For pur-
15	poses of this section—
16	"(A) In general.—The term 'group health
17	plan' shall have the meaning provided in section
18	733(a).
19	"(B) Treatment of partnerships.—The
20	provisions of paragraphs (1), (2), and (3) of sec-
21	$tion \ 732(d) \ shall \ apply.$
22	"(10) Other definitions.—For purposes of
23	this subsection—
24	"(A) REQUEST FOR BENEFIT PAYMENTS.—
25	The term 'request for benefit nauments' means a

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request, for payment of benefits by a group health plan for medical care, which is made by, or (if expressly authorized) on behalf of, a participant or beneficiary after such medical care has been provided.

"(B) REQUIRED DETERMINATION OF MEDI-CAL NECESSITY.—The term 'required determination of medical necessity' means a determination required under a group health plan solely that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan's requirements for medical appropriateness or necessity (which may be subject to exceptions under the plan for fraud or misrepresentation), irrespective of whether the proposed medical care otherwise meets other terms and conditions of coverage, but only if such determination does not constitute an advance determination of coverage (as defined in subparagraph (C)).

"(C) ADVANCE DETERMINATION OF COV-ERAGE.—The term 'advance determination of coverage' means a determination under a group health plan that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan's terms and condi-

1	tions of coverage (which may be subject to excep-
2	tions under the plan for fraud or misrepresenta-
3	tion).
4	"(D) REQUEST FOR ADVANCE DETERMINA-
5	TION OF COVERAGE.—The term 'request for ad-
6	vance determination of coverage' means a request
7	for an advance determination of coverage of med-
8	ical care which is made by, or (if expressly au-
9	thorized) on behalf of, a participant or bene-
10	ficiary before such medical care is provided.
11	"(E) Request for expedited advance
12	DETERMINATION OF COVERAGE.—The term 're-
13	quest for expedited advance determination of cov-
14	erage' means a request for advance determina-
15	tion of coverage, in any case in which the pro-
16	posed medical care constitutes accelerated need
17	medical care.
18	"(F) Request for required determina-
19	TION OF MEDICAL NECESSITY.—The term 're-
20	quest for required determination of medical ne-
21	cessity' means a request for a required deter-
22	mination of medical necessity for medical care
23	which is made by or on behalf of a participant
24	or beneficiary before the medical care is pro-

25

vided.

1	"(G) Request for expedited required
2	DETERMINATION OF MEDICAL NECESSITY.—The
3	term 'request for expedited required determina-
4	tion of medical necessity' means a request for re-
5	quired determination of medical necessity in any
6	case in which the proposed medical care con-
7	stitutes accelerated need medical care.
8	"(H) Accelerated need medical
9	CARE.—The term 'accelerated need medical care'
10	means medical care in any case in which an ap-
11	propriate physician has certified in writing (or
12	as otherwise provided in regulations of the Sec-
13	retary) that the participant or beneficiary is sta-
14	bilized and—
15	"(i) that failure to immediately pro-
16	vide the care to the participant or bene-
17	ficiary could reasonably be expected to re-
18	sult in—
19	"(I) placing the health of such
20	participant or beneficiary (or, with re-
21	spect to such a participant or bene-
22	ficiary who is a pregnant woman, the
23	health of the woman or her unborn
24	child) in serious jeopardy;

1	"(II) serious impairment to bod-
2	ily functions; or
3	"(III) serious dysfunction of any
4	bodily organ or part; or
5	"(ii) that immediate provision of the
6	care is necessary because the participant or
7	beneficiary has made or is at serious risk of
8	making an attempt to harm himself or her-
9	self or another individual.
10	"(I) Initial decision period.—The term
11	'initial decision period' means a period of 30
12	days, or such longer period as may be prescribed
13	in regulations of the Secretary.
14	"(J) Internal review period.—The term
15	'internal review period' means a period of 30
16	days, or such longer period as may be prescribed
17	in regulations of the Secretary.
18	"(K) Accelerated need decision pe-
19	RIOD.—The term 'accelerated need decision pe-
20	riod' means a period of 3 days, or such period
21	as may be prescribed in regulations of the Sec-
22	retary.
23	"(L) Reconsideration period.—The term
24	'reconsideration period' means a period of 25

1	days, or such longer period as may be prescribed
2	in regulations of the Secretary, except that—
3	"(i) in the case of a decision involving
4	urgent medical care, such term means the
5	urgent decision period; and
6	"(ii) in the case of a decision involving
7	accelerated need medical care, such term
8	means the accelerated need decision period.
9	"(M) FILING COMPLETION DATE.—The term
10	'filing completion date' means, in connection
11	with a group health plan, the date as of which
12	the plan is in receipt of all information reason-
13	ably required (in writing or in such other rea-
14	sonable form as may be specified by the plan) to
15	make an initial coverage decision.
16	"(N) Review filing date.—The term 're-
17	view filing date' means, in connection with a
18	group health plan, the date as of which the ap-
19	propriate named fiduciary (or the independent
20	medical expert or experts in the case of a review
21	under paragraph (4)) is in receipt of all infor-
22	mation reasonably required (in writing or in
23	such other reasonable form as may be specified
24	by the plan) to make a decision to affirm, mod-
25	ifu, or reverse a coverage decision.

1	"(O) MEDICAL CARE.—The term 'medical
2	care' has the meaning provided such term by sec-
3	tion 733(a)(2).
4	"(P) Health insurance coverage.—The
5	term 'health insurance coverage' has the meaning
6	provided such term by section $733(b)(1)$.
7	"(Q) Health insurance issuer.—The
8	term 'health insurance issuer' has the meaning
9	provided such term by section $733(b)(2)$.
10	"(R) Written or in writing.—
11	"(i) In general.—A request or deci-
12	sion shall be deemed to be 'written' or 'in
13	writing' if such request or decision is pre-
14	sented in a generally recognized printable
15	or electronic format. The Secretary may by
16	regulation provide for presentation of infor-
17	mation otherwise required to be in written
18	form in such other forms as may be appro-
19	priate under the circumstances.
20	"(ii) Medical appropriateness or
21	INVESTIGATIONAL ITEMS OR EXPERIMENTAL
22	TREATMENT DETERMINATIONS.—For pur-
23	poses of this subparagraph, in the case of a
24	request for advance determination of cov-
25	erage, a request for expedited advance deter-

1	mination of coverage, a request for required
2	determination of medical necessity, or a re-
3	quest for expedited required determination
4	of medical necessity, if the decision on such
5	request is conveyed to the provider of medi-
6	cal care or to the participant or beneficiary
7	by means of telephonic or other electronic
8	communications, such decision shall be
9	treated as a written decision.".
10	SEC. 3. CLARIFICATION OF ERISA PREEMPTION RULES.
11	(a) In General.—Section 514 of the Employee Re-
12	tirement Income Security Act of 1974 (29 U.S.C. 1144) is
13	amended—
14	(1) by redesignating subsection (d) as subsection
15	(e); and
16	(2) by inserting after subsection (c) the following
17	new subsection:
18	"(d) The procedures and remedies required or provided
19	under sections 502 and 503 in connection with—
20	"(1) review of claims for benefits under employee
21	benefit plans and for review of decisions denying such
22	claims (including review of coverage decisions referred
23	to in section 503(b) and decisions upon review of such
24	coverage decisions), and

- 1 "(2) causes of action brought to recover plan ben-
- 2 efits, to enforce rights under the terms of the plan or
- 3 this title, or to clarify rights to future benefits under
- 4 the terms of the plan or this title,
- 5 are the exclusive procedures and remedies with respect to
- 6 any such review or cause of action and supersede any provi-
- 7 sion of State law providing for any such review or cause
- 8 of action.".
- 9 (b) Conforming Amendment.—Section 514(b)(2)(A)
- 10 of such Act (42 U.S.C. 1144(b)(2)(A)) is amended by insert-
- 11 ing "or subsection (d)" after "subparagraph (B)".
- 12 SEC. 4. EFFECTIVE DATE.
- 13 (a) In General.—The amendments made by this Act
- 14 shall apply with respect to grievances arising in plan years
- 15 beginning on or after January 1 of the second calendar year
- 16 following 12 months after the date the Secretary of Labor
- 17 issues all regulations necessary to carry out amendments
- 18 made by this Act.
- 19 (b) Limitation on Enforcement Actions.—No en-
- 20 forcement action shall be taken, pursuant to the amend-
- 21 ments made by this Act, against a group health plan or
- 22 health insurance issuer with respect to a violation of a re-
- 23 quirement imposed by such amendments before the date of
- 24 issuance of final regulations issued in connection with such

- 1 requirement, if the plan or issuer has sought to comply in
- 2 good faith with such requirement.
- 3 (c) Collective Bargaining Agreements.—Any
- 4 plan amendment made pursuant to a collective bargaining
- 5 agreement relating to the plan which amends the plan solely
- 6 to conform to any requirement added by this Act shall not
- 7 be treated as a termination of such collective bargaining
- 8 agreement.